DELAWARE **PrescriptionAssistance** PROGRAM

A prescription for better health

EDS DPAP
P.O. Box 950
New Castle DE
19720-9914

Please complete and sign this form and return it to the address on the back of form. Your eligibility for this program cannot be reviewed unless your application is signed and copies of all documents requested are attached.

1. Applicant Name/Address

Last Name	First Name	MI	Social Security Number	Marital Status
			- -	☐Married ☐Divorced ☐Widowed ☐Never Married ☐Separated

Street	Apt. No.	City	Zip	County	Phone Number
			19	N K S	302-

Race (optional)	Sex	Date of Birth	Citizen of the USA	Receiving Medicare	Eligible for Nemours	Other Pharmacy Coverage
	Male Female	/ /	Yes No	Yes No	Yes No	Yes No If Yes: Name of Plan: _____ Phone Number: _____

Receiving Social Security Benefits: Yes No **If Yes, attach proof of benefit.**

2. Income

Documentation (or proof) must be provided with this application. Photocopies only, no original forms.

Your and **your spouse's income** must be reported. Social Security, Veterans Benefit, pension, earnings, interest on savings and/or investments, cash given to you or any other income must be reported.

Married couples fill out separate forms; list joint income on both applications. Mail applications in the same envelope.

☐ Am not required to file federal income tax forms.

Attach a separate sheet for additional space.

Source of Income	How often	Amount After taxes/deductions

Number of dependent children living in the home _____

RIGHTS AND RESPONSIBILITIES

I have read or have had read to me all of the statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.

I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I understand and agree to give proof of my statements. I understand that the Department of Health and Social Services may contact other persons or organizations to obtain the necessary proof of my eligibility.

_____ _____

Signature of Applicant or Representative Date
If representative, please print name, relationship and phone number.

Name: _____ Relationship: _____ Phone: _____